Thoughts on patriarchy

I felt I could not let the diatribe posing as a scientific article by Professor Malcolm Potts and his wife, Dr Martha Campbell, go without comment on one reads an article that contains gross inaccuracy, even in part, the credibility of the rest and of the journal running it is thrown into question.

The article has an understandable modern problem with St Augustine but that is no excuse for their absurdly inaccurate summary of over a hundred theological works; that he “saw God as an arbitrary judge who could be placated by bribes”. Nor does it justify ridiculing him from a 21st century perspective with no attempt to understand his historical or personal context, or indeed the context of any of the other (highly selected) examples. To then link patron saints in a non sequitur to bribery and the etymology of ‘grace’ (wrongly) to the same is as ridiculous as it is irrelevant. (I note they are only able to quote Potts’ own authority for this).

To limit the development of Christian sexual ethics only to the context of sexual exploitation tolerated in the Roman Empire is profoundly misleading. They show no awareness of the contributing influences of Judaism, Hellenism, Stoicism or Gnosticism.

How blinkered the authors’ historical viewpoint is can be seen from the fact that the discussion is limited to one theologian among many, to only the Western tradition, ignoring Eastern and Catholic perspectives completely, and subsequently narrowing within that to Roman Catholicism.

Islam fares worse, seeming only to be represented by the Taliban in the authors’ minds. If the two faiths both have “liberal and conservative interpretations”, why is discussion limited to the negative ones?

The most one learns from this article is something of the prejudices of its authors. This is not the first time Malcolm Potts has been accused of a lack of objectivity.

Space precludes a more detailed response but I wonder how this got through the Journal’s peer review process. It would have been sensible to mention Martha Campbell’s membership of the Editorial Advisory Board as a competing interest. In a journal aspiring to international scientific respectability, authors should be obliged to give balanced and informed discussion. It is polemic to be part of the offering, it should be flagged as such.

I am certainly no friend of patriarchy, but a scientific article is not the place to abandon ethics only to the context of sexual exploitation tolerated in the Roman Empire. We appreciate Dr Shepherd’s broader view of the problem such as multiple scars, infection, bruises, nerve and vessel injury and their consequences.

Even though the Mansour et al. article mentioned a vertical incision for removal I went through the original horizontal scar and carefully dissected tissues vertically and removed four rods by making incisions at 2 cm above and below the scar. Rather than attempting the heroic removal of the remaining two rods (located laterally and above) through the same incision, I felt it was much safer and easier to employ two small incisions (<2 cm each) and use the ‘pop-out’ technique, similar to Implanon removal. This avoided a T-incision with the old scar and I hope the patient will end up with only the single, old incision scar. A patient review visit after 1 week confirmed a nicely healing wound. I discharged the patient from the clinic since she had not decided on her future contraception, except the use of condoms. The patient was extremely happy to have avoided referral to an unknown clinic for removal of her Norplant.

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Implant removal by modifying access

I read with great interest the review articles by Diana Mansour and colleagues on ‘Methods of accurate localisation of the non-palpable subdermal contraceptive implant’ and ‘Removal of non-palpable subdermal contraceptive implants’ in the January and April 2008 issues of the Journal, respectively.1,2 I totally agree with the author’s suggestion to modify access with 2–3 ml of local anaesthetic applied under the palpable portion. This helped me greatly to modify the procedure, depending upon the patient’s clinical circumstances and requirements as outlined in the following two cases:

Case 1: A 24-year-old mother of two children was fitted with Implanon® 18 months previously. The patient requested removal of the Implanon for her next conception. On examination the distal end of the implant was non-palpable and the proximal end was palpable with difficulty. An ultrasound scan was done as suggested in the article. The ultrasonic report noted that “the Implanon is located in the left arm, the lower edge is marked and is at a depth of 1.6 cm. The upper edge is palpable”. After explaining the possible difficulties, I obtained fully informed, written consent from the patient for removal of her implant. I made a 4 mm incision at the proximal, barely palpable, end of the Implanon and dissected it from subdermal tissue, 1998–99, and finally managed to get the Implanon out with only the single, old scar, infection, bruises, nerve and vessel injury and their consequences.

Norplant removal forceps

I was interested to read the article by Diana Mansour et al., the only advantage to the Norplant implants is the one in the arm. The Norplant removal forceps have a single use instrument policy, and we have had to get rid of our desktop sterilisers, so we are no longer able to reuse the modified vasectomy forceps (“Norplant device”) as recommended in the article.

References


References


Competing interest

The author is in training as a Reader in the Church of England.
Figure 1 Disposable vasoectomy forceps used for Nonpalt Surgical Instruments.

Reply

We thank Anne Bennett for her comments related to our article describing removal techniques for contraceptive implants.

The main organisations are bringing in 'single-use instruments policies' as a result of new NHS guidance on decontamination aimed at improving the quality of surgical instrument reprocessing across the health care cectors in England. Finding manufacturers who are prepared to supply small numbers of specialist disposable surgical instruments is difficult, however we have good news.

Disposable modified vasoectomy forceps can now be obtained for about £2 from the supplier mentioned below. This company is also making the new sterilisation technique for the Dalkon Shield® better known.

Contact: Unisurge International Ltd, Unit N, Dales Manor Business Park, East Way, Sawston, Cambridge CB2 4TJ, UK. Tel: 01223 839911. E-mail: info@unisurge.com.

Diana Mansour, FRCOG, FFSRH
Head of Service, Newcastle Contraception and Sexual Health, Graingerville Clinic, Newcastle General Hospital, Newcastle upon Tyne, UK. E-mail: Diana.Mansour@newcastle.pct.nhs.uk

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Reference

Pharmacy-based sexual health services and clinical governance

I read with interest the Editorial by Beth Taylor in the July 2008 issue of the Journal.

I agree that the time is right to develop vision to embrace additional providers of the sexual health service. The new pharmacist’s contract is a welcome development in this direction.

As Beth Taylor highlighted, there is certainly a need for educational and training support from specialist services in order to avoid isolation. To achieve this, a robust professional link would be the development of a linked Clinical Governance Plan with local specialist services.

The uptake of the newly launched online chargeable repeat contraception service would give an indication of clients’ willingness to pay for such services.

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Reference

Treatment of perimenopausal menorrhagia with Implanon®

I write concerning the successful treatment of perimenopausal menorrhagia with Implanon® in a 53-year-old woman. The patient (date of birth early 1953) was seen at the surgery in October 2004 with symptoms of flushing and regular periods. In early 2006 she developed menorrhagia, which was investigated with normal hysteroscopy and intrauterine system (IUS) insertion in early August 2006. The IUS was expelled after 2 months in situ and after ongoing symptoms of polymenorrhagia. After some discussion with the patient regarding treatment options, she decided to trial Implanon insertion, aware that it was not a clinically recognised treatment option for menorrhagia. The insertion was carried out in early October 2006.

On review in August 2008 the patient noted light bleeds in March and April 2007, and a 2-day light bleed in May 2008. She stated that she “was willing to recommend Implanon” because of the important clinical effect of Implanon in the treatment of perimenopausal menorrhagia.

I plan to write to the manufacturer concerned, namely Organon, concerning this important clinical effect of Implanon in the treatment of perimenopausal menorrhagia. I would be interested to hear if other practitioners have anecdotal evidence of Implanon being used in this way.

Libby M. Wilson, MBBS, FFSRH
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